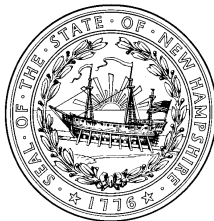


OFFICE OF PROFESSIONAL LICENSURE AND CERTIFICATION
STATE OF NEW HAMPSHIRE
DIVISION OF LICENSING AND BOARD ADMINISTRATION
Board of Medicine
7 Eagle Square
Concord, N.H. 03301-2412
Telephone 603-271-2152



APPLICATION FOR LICENSURE

INSTRUCTIONS

GENERAL INFORMATION

Board Application Process

1. **All applicants for licensure in New Hampshire are required to submit their background credentials to the Federation Credentials Verification Service (FCVS).** FCVS is a service of the Federation of State Medical Boards, a non-profit organization representing the 70 medical and osteopathic boards of the United States and its territories. FCVS was created to help simplify the licensure process for physicians (both MDs and DOs).

By eliminating the re-verification of documents that never change, physicians benefit from a shortened credentialing process when applying to another state board. This profile can be updated and sent to boards and other entities as needed. Currently, 55 medical boards accept FCVS profiles in lieu of the applicant providing original credentials for verification. New Hampshire and 13 other state boards require all applicants to use FCVS for credentials verification.

FCVS requires a one-time submission of education and training documents directly to a depository maintained by FSMB. The documents verified and securely stored include:

- Identity
- Medical Education
- Postgraduate Training
- Exam History (state licensing authorities only)
- Board Action/Disciplinary History
- ABMS Board Certification
- ECFMG Certification (if applicable)

2. **All applicants must also complete the Uniform Application for Physician State Licensure (UA),** another service provided by FSMB. Similar to FCVS, the UA eliminates redundancy when applying to multiple participating states. After completing the UA for the first time, your application is securely stored and can be resubmitted to another board without reentering the same information. You would make updates as needed and complete board-specific requirements.
3. **In addition to the FCVS and UA applications and processes, you must submit additional information directly to the Board.** The Board will use this information, along with the FCVS profile, to assess your qualifications for licensure. The Board conducts an independent background investigation. Please allow a minimum of 8 weeks for the entire licensure process to be completed. If you have malpractice or disciplinary history, it can take an additional 2 or 3 months for all pertinent documentation to be received.

The Board meets and reviews applications on the first Wednesday of each month. Only applications that are complete, including all outside verifications, will be forwarded to the Board for review. The agenda for Board consideration is closed at 12:00 pm on the Friday before the Board meets. Applications completed after 12:00 pm will be placed on the next month's agenda. Faxed materials are not acceptable. Licenses will be issued within 7-10 working days following the Board meeting and are emailed to the email address furnished in your application. You are responsible for notifying the Board office, in writing, if your address changes in the interim.

Please continue to review the remaining portions of this application packet for instructions and other materials necessary to complete the Board application. If you have questions about this application process or would like to check on the status of your Board application, please call the Board at (603) 271-2152.

Temporary License Application Process

Since the FCVS application process is fairly lengthy, and unless you already have an FCVS profile, you may want to apply for a temporary license in New Hampshire. A temporary license, if issued, is valid for only 6 months and requires you to provide a completed application, with the exception of the FCVS application, and additional information as follows:

1. Evidence of qualifications as follows:
 - a. Proof of a full, unrestricted medical license in another state received directly from the state licensing authority; or

- b. Certified copies of medical degree diploma, proof of 2 years of postgraduate training which meet the requirements of Med 302.01, and proof that you have passed one of the licensure examinations listed under Med 303.01;
2. Proof that you have applied to the FCVS with full intent to complete the FCVS process; and
3. The temporary license fee of \$55.00. Make check payable to TREASURER, STATE OF NEW HAMPSHIRE. **Please submit one check for the temporary license fee (\$55.00) and a separate check for the full license application fee (\$385.00). Fees are not refundable.**

**** Before applying for the temporary license, please contact the New Hampshire facility you are applying at to confirm that they accept the temporary license.**

Licensure Requirements

Before completing the application process, please review the following requirements for licensure in New Hampshire:

- Obtained the M.D./D.O. degree or its equivalent as determined by the Board;
- Completed at least 2 years of postgraduate training in the U.S. or Canada approved by the Board, or its equivalent as determined by the Board;
- Successfully passed a national licensing examination sequence (or its acceptable hybrid combination) as approved by the Board on each examination, including:
 - National Board of Medical Examiners (NBME) Part I, II and III;
 - Pre-1985 FLEX or FLEX Component 1 and 2;
 - USMLE Step 1, 2 and 3;
 - NBOME Part I, II and III (or COMLEX);
 - Licentiate of the Medical Council of Canada (LMCC).

If you do not meet, or have questions about these requirements, please contact the Board prior to submitting your application.

General Instructions

1. All documents you submit must be originals, signed on letterhead unless notarized copies are specifically authorized.
2. You will receive an acknowledgment letter once your application has been received. This letter will advise you of what information, if any, is outstanding at that time. If you do not receive an acknowledgment letter within 30 days, please contact the Board between 8:00 A.M. and 4:00 P.M. EST.
3. With the acknowledgement letter, you will receive paperwork to complete a criminal background check. **Pursuant to RSA 329:11-a, you are required to submit a notarized criminal history record release form, along with a fee, which authorizes the release of your criminal history record, if any, to the Board. This form will be provided to you with your acknowledgment letter once your application has been received by the Board. PLEASE NOTE: the criminal history submitted to the Board from the N.H. Division of State Police shall only be valid for three (3) months from the time it's received in the Board's office.**
4. Make a check, postal or express money order (in U.S. funds only) for the application fee of **\$385.00** payable to: TREASURER, STATE OF NEW HAMPSHIRE and staple it to the upper left-hand corner of the first page of the addendum. This application fee is **non-refundable**. [NOTE: This is the Board application fee. The FCVS verification fee is an additional and separate fee paid directly to FCVS.]

(An additional \$55.00 fee is required if requesting a temporary license. Please submit one check for the temporary license fee (\$55) and a separate check for the full license application fee (\$385).

5. Original letter of reference, on letterhead and addressed to the board, from:
 - a. The chief medical officer or president of the medical staff in every hospital in which the applicant currently holds staff privileges; or
 - b. Letters of reference from 2 practicing physicians.

Reference letters must be originals submitted on letterhead. References may be submitted by the applicant or by the physician providing the reference.

6. Submit a notarized copy of your American Board of Medical Specialty Certificate(s), if applicable.
7. Submit your curriculum vitae.
8. Submit a notarized copy of your current Drug Enforcement Administration (DEA) certificate.

Use the checklist at the end of this document to ensure you submit everything needed. Mail the items listed to:

**NEW HAMPSHIRE BOARD OF MEDICINE
7 Eagle Square
CONCORD, NEW HAMPSHIRE 03301-2412**

Other Information

Your application process is not considered complete until your Board application, licensure verification(s), and FCVS Physician Information Profile are received in a manner satisfactory to the Board. The Board will not accelerate processing of one applicant at the expense of others for any reason. Once completed, your application will be reviewed at the first available Board meeting. Please allow 7-10 working days following the Board meeting for your license to be mailed to you.

Note: Do NOT make commitments to start practicing medicine in New Hampshire until you have been issued a license.

INSTRUCTIONS FOR COMPLETING THE BOARD APPLICATION

To work on your FCVS application for credentials verification, visit <https://portal.fsmb.org/MyFsmb/> and click on the FCVS graphic, then sign in. You may also visit <http://www.fsmb.org/> and click on FCVS in the Licensure menu to access the portal page. Please note: Designations to Self are for receiving your own copy of the profile. Boards do not accept Self designations.

If you are using FCVS for the first time, complete an Initial FCVS Application. If you are updating your existing FCVS profile, complete a Subsequent FCVS Application. During the application process, designate your profile to be received by the New Hampshire Board of Medicine. A profile with a Self designation will not be accepted.

For assistance with FCVS, use the messaging tool within FCVS or call 888-275-3287 with your FCVS ID number between 8am and 5pm CT Monday through Friday.

To work on your Uniform Application for licensure, visit <https://portal.fsmb.org/MyFsmb/> and click on the UA graphic, then sign in. You may also visit <http://www.fsmb.org/> and click on Uniform Application in the Licensure menu to access the portal page.

For UA assistance, see the UA FAQ at <http://www.fsmb.org/licensure/uniform-application/faq>. If your issue is not listed, contact UA customer service at 800-793-7939 or ua@fsmb.org with a description of the problem. If you see an error message, please email a screenshot.

Please note the following:

- You will be asked to complete a chronology of activities of all working and non-working time since medical school graduation and provide details of any malpractice liability claims. Having this information on hand before you begin will help you to complete the UA more efficiently. Failure to submit all required information and documentation will result in processing delays.
- If not pre-filled, provide your home address and a separate address for business or postgraduate training. Both Board Contact and Public Access selections must be made but you can use the same address for each selection. All home addresses must be domestic, as fingerprint cards and other background information are mailed there.
- The Board is required to obtain your SSN for the purpose of child support enforcement and in compliance with RSA 161-B:11. This collection of your SSN is mandatory.
- If not pre-filled, enter each training program in the United States and Canada in either the ACGME Training page or the Other Training page. Enter postgraduate programs outside of the United States and Canada on the Chronology page.
- You are not able to add or edit MD or DO license information in the UA because that information is sent directly from the state boards into the FSMB system. If changes are needed, email ua@fsmb.org with the correct information. Depending on volume of license update requests, it may take 1-3 business days for the changes to appear in your UA. Do not enter MD or DO license information under “Other”.
- If you hold a medical or osteopathic license or licenses in countries outside of the United States or Canada, provide that information on a separate sheet of paper to the Board.
- Your Chronology of Activities should cover each of your activities (non-working time included) from medical school graduation to present. Previously listed medical school and postgraduate training programs will pre-fill the Chronology. Do not leave gaps. For each entry, use the first day of the month for start and end dates unless you know the exact date. If you have military or locum tenens assignments, list each location separately.
- Clinical time indicates time spent seeing patients and practicing medicine. Administrative time indicates time spent on paperwork, research, or teaching.
- Leave the malpractice liability claims section blank only if you have had no claims. List all pending claims.
- Upon accepting the Terms and Agreement and submitting the UA, first time UA users will be taken to a payment page for the one-time service charge. This charge sustains the UA program and is separate from FCVS and state board licensing fees.
- For a copy of your receipt, click on the “Home” link to return to the portal page, which will now have a Payment link to all FSMB receipts in the upper right corner.
- To open your UA for editing and resubmitting to a board, or for submitting to a new board, sign in and choose the appropriate board in the State Board section. Reselect the US Citizen query on the Identification page (it resets each time a UA is submitted), make changes as needed, then submit or resubmit your UA.
- Refer to the UA FAQ at <https://www.fsmb.org/licensure/uniform-application/faq> for answers to the most common UA questions. If your issue isn't listed, contact UA customer service at 800-793-7939 or email ua@fsmb.org with your username and a description of your issue. Provide a screenshot for each error you see.

In addition to completing the core UA online, applicants must:

- Submit a notarized UA Affidavit and Authorization for Release of Information form to the Board. The UA Affidavit is separate from the FCVS Affidavit and must be sent to the Board, not to FCVS or FSMB. Follow the instructions on the form.

- Have each full, temporary, training, or limited healthcare or profession license or certification you have ever held in the United States or Canada verified by the granting board, whether the license is currently active or inactive. To determine the fees and preferred verification method for each board, use the resource at <http://www.fsmb.org/licensure/uniform-application/>. If a board uses VeriDoc or other electronic format for verifications, do not use the UA verification form. **PLEASE NOTE: the verification shall only be valid for six (6) months from the time it's received in the Board's office.**
- Complete the FCVS initial or subsequent application.
- Complete all other board requirements as instructed.

BOARD APPLICATION CHECKLIST

Completed FCVS application and paid all applicable fees to FSMB ☐

Completed online Uniform Application ☐

Mailed the following items to the New Hampshire Board of Medicine:

- Completed state universal application for initial licensure and addendum ☐
- Notarized UA Affidavit and Authorization for Release of Information form ☐
- Check, postal or express money order in U.S. funds for the total application fee of \$385.00 made payable to TREASURER, STATE OF NEW HAMPSHIRE ☐
- Separate check, postal or express money order in U.S. funds for the temporary license fee of \$55.00 made payable to TREASURER, STATE OF NEW HAMPSHIRE (if applicable) ☐
- Two letters of reference (see General Instructions, #5 at the bottom of page 2) ☐
- Notarized copy of your American Board of Medical Specialty (ABMS) Certificate(s) (if applicable) ☐
- Curriculum vitae ☐
- Notarized copy of your current Drug Enforcement Administration (DEA) certificate ☐

Completed and mailed Licensure Verification Form and fee, if applicable, to each state board with which you have ever held any healthcare license, or used VeriDoc or the verifying board's preferred method of verification ☐

OFFICE OF PROFESSIONAL LICENSURE AND CERTIFICATION
STATE OF NEW HAMPSHIRE
DIVISION OF LICENSING AND BOARD ADMINISTRATION
Board of Medicine
7 Eagle Square
Concord, N.H. 03301
Telephone 603-271-1203

STATE ADDENDUM

Instructions: Print out the state addendum. Complete as instructed and mail to:

NEW HAMPSHIRE BOARD OF MEDICINE
7 EAGLE SQUARE
CONCORD, NEW HAMPSHIRE 03301

Other Information

Your application process is not considered complete until your Board application, licensure verification(s), and FCVS Physician Information Profile are received in a manner satisfactory to the Board. The Board will not accelerate processing of one applicant at the expense of others for any reason. Once completed, your application will be reviewed at the first available Board meeting. Please allow 7-10 working days following the Board meeting for your license to be mailed to you.

Note: Do NOT make commitments to start practicing medicine in New Hampshire until you have been issued a license.

ADDENDUM TO APPLICATION

Applicant Name _____ Date _____

Please answer the following questions. **If you answer “yes” to any of these questions, please explain on the reverse side of this sheet, or attach an additional 8 ½” x 11” sheet(s) if necessary.**

1. Have you been actively engaged in the practice of clinical medicine within the past 12 months? Yes ☐ No ☐
2. Are you certified by an American Specialty Board? (If yes, provide a notarized copy of all certificates.) Yes ☐ No ☐
3. Have you ever, for any reason, lost American Specialty Board Certification? Yes ☐ No ☐
4. Have you been denied required recertification by any specialty boards? (If yes, list each board and dates denied.) Yes ☐ No ☐
5. Has any medical malpractice suit been brought against you or has any claim been settled on your behalf in the last ten years? (If so, list each suit/claim on the Malpractice Liability Claims Information page within the online Uniform Application.) Yes ☐ No ☐
6. Have you ever applied for licensure or to sit for an examination, or taken an examination, under a different name? Yes ☐ No ☐
7. Have you ever been denied the privilege of taking or finishing an examination or been accused of cheating or improper conduct during an examination since you graduated from high school? Yes ☐ No ☐
8. Have you ever failed any national medical licensure examination or any part of that examination, state board examination, or failed to gain certification from the National Board of Medical Examiners? **You must report all exam failures, even if you later passed the examination.** (This does not include specialty board certification examinations.) Yes ☐ No ☐
9. Have you ever failed a foreign licensing or certification examination? Yes ☐ No ☐
10. Have you ever been denied a medical license, whether full, limited, or temporary, for any reason? Yes ☐ No ☐
11. Have you ever had staff privileges, employment or appointment in a hospital or other health care institution denied, limited, suspended, or revoked, or have you ever resigned from a medical staff in lieu of disciplinary action? Yes ☐ No ☐
12. Is any investigation or disciplinary action pending, or has any investigation or disciplinary action been taken against you in the last ten years by any governmental authority, by any hospital or health care facility, or by any professional medical association (international, national, state, or local)? Yes ☐ No ☐
13. Have you ever voluntarily surrendered a license to practice medicine or any healing art or allowed such a license to lapse in lieu of facing disciplinary investigation or action? Yes ☐ No ☐
14. Have you ever withdrawn an application for licensure, hospital privileges, or appointment for any reason? Yes ☐ No ☐

Applicant Name _____ **Date** _____

15. Have you ever been a defendant in a criminal proceeding including driving while under the influence or driving while suspended, which has not been annulled by a court, but not including traffic offenses not classified as misdemeanors or felonies? Yes ☐ No ☐

16. Has your privilege to possess, dispense, or prescribe controlled substances ever been suspended, revoked, denied, restricted, or surrendered, or have you ever been charged, investigated, or warned by a state or federal agency based on controlled substance issues? Yes ☐ No ☐

17. The NH Board of Medicine ("Board") acknowledges that it is not only normal but anticipated and acceptable for a physician or a physician assistant to feel overwhelmed from time to time and to seek help when appropriate. The Board emphasizes the importance of provider health, self-care, and appropriate treatment for all health conditions. The Board supports the NH Professionals Health Program ("NHPHP"). The NHPHP provides free-of-charge, confidential and "safe-haven non-reporting" intake assessments, referrals and monitoring (when appropriate) for all NH physicians and physician assistants who have potentially impairing or troubling conditions such as substance use, mental health conditions, burnout, physical illness or disruptive behavior. The Board encourages all providers to read about the NHPHP, provider wellness and resources found at www.nhphp.org.

Are you currently suffering from any condition, mental or physical that impairs your judgment or that would otherwise adversely affect your ability to practice medicine in a competent, ethical and professional manner?

Yes ☐ No ☐

18. Are you currently or have you in the past been monitored or treated by a private, state, medical society or hospital physician health program, other than through the NH board approved physician health program? Yes ☐ No ☐

Anticipated Practice Location(s) (if known):

Applicant's Signature

Applicant's Printed Last Name

Date of Signature

For Board Use Only:

Application Received: _____, 20____ Fee Paid: _____ Check # _____

License Number: _____ Date of Issue: _____

Affidavit and Authorization for Release of Information

Applicant: In the presence of a notary public, sign this form with attached photo. Consider having the FCVS affidavit notarized at the same time. Send the separate notarized FCVS form to FCVS. **Do not send this form to FCVS** as doing so will delay your licensure.

Send this form to the **New Hampshire Board of Medicine:**

7 Eagle Square, Concord, NH 03301-2412. Include all other required materials.

To the New Hampshire Board of Medicine,

I, the undersigned, being duly sworn, hereby certify under oath that I am the person named in this application, that all statements I have made or shall make with respect thereto are true, that I am the original and lawful possessor of and person named in the various forms and credentials furnished or to be furnished with respect to my application, and that all documents, forms, or copies thereof furnished or to be furnished with respect to my application are strictly true in every aspect.

I acknowledge that I have read and understand the Uniform Application for Physician State Licensure and have answered all questions contained in the application truthfully and completely. I further acknowledge that failure on my part to answer questions truthfully and completely may lead to my being prosecuted under appropriate federal and state laws.

I authorize and request every person, hospital, clinic, government agency (local, state, federal, or foreign), court, association, institution, or law enforcement agency having custody or control of any documents, records, and other information pertaining to me to furnish to the Board any such information, including documents, records regarding charges or complaints filed against me, formal or informal, pending or closed, or any other pertinent data, and to permit the Board or any of its agents or representatives to inspect and make copies of such documents, records, and other information in connection with this application.

I hereby release, discharge, and exonerate the Board, its agents or representatives, and any person, hospital, clinic, government agency (local, state, federal, or foreign), court, association, institution, or law enforcement agency having custody or control of any documents, records, and other information pertaining to me of any and all liability of every nature and kind arising out of investigation made by the Board.

I will immediately notify the Board in writing of any changes to the answers to any of the questions contained in this application if such a change occurs at any time prior to a license to practice medicine being granted to me by the Board.

I understand my failure to answer questions contained in this application truthfully and completely may lead to denial, revocation, or other disciplinary sanction of my license or permit to practice medicine.

Applicant Photograph

Securely tape or glue a recent (per the board's instructions) front-view 2" x 2" passport-type color photo of yourself in this square.

Applicant's signature (must be signed in the presence of a notary)

Applicant's printed last name, first name, middle initial, and suffix (e.g., Jr.)

Date of signature (must correspond to date of notarization)

[Please note: The Notary Public seal should overlap the bottom of the photo to the left.]

NOTARY

State of _____, County of _____,

I certify that on the date set forth below, the individual named above did appear personally before me and that I did identify this applicant by: (a) comparing his/her physical appearance with the photograph on the identifying document presented by the applicant and with the photograph affixed hereto, and (b) comparing the applicant's signature made in my presence on this form with the signature on his/her identifying document.

The statements on this document are subscribed and sworn to before me by the applicant on this _____ day of _____, 20____.

Notary Public Signature _____ My Notary Commission Expires _____

Licensure Verification Form (Form #1)

Applicant: Most boards require verification of each professional license ever held. Refer to the licensure verification resource at <http://www.fsmb.org/licensure/uniform-application/> to determine fees and preferred verification method(s) for each state medical and osteopathic verifying board. You may use this form for each board that requires a written request for verification. Mail this completed form and any required fee to the verifying board.

Verifying Board: Unless using electronic verification, complete Section 2 below and mail this form to the board at the address listed in Section 1. Use an additional sheet of paper if needed for explanation(s).

Section 1: Applicant Information

First name _____ Last name _____ Practitioner Type ☐ MD ☐ DO ☐ _____
Middle name _____ Suffix _____ SSN* _____ Birth date (mm/dd/yyyy) _____

*The social security number is to be used for purposes of identification only and may not be used for any other reason.

Authorization for Verifying Board: I am applying for a license to practice medicine. The board that I am applying to for licensure requires that this form or an otherwise accepted method of verification be completed by all boards through which I hold or have held licenses, whether now current or not. I authorize the licensing agency of the state/province of _____ to provide any and all information pertaining to my license number _____ to the board at the address listed below.

Board name
Mailing address
City/State/Zip

**NEW HAMPSHIRE BOARD OF MEDICINE
7 Eagle Square.
CONCORD, NEW HAMPSHIRE 03301-2412**

Applicant signature _____ Date _____

Section 2: Board Verification of Licensure

Name of issuing board or license entity _____

Name of licensee (last, first, middle, suffix) _____

License type _____ License number _____ Issue date _____ Expiration date _____

1. Is this license current? If not current, please explain: ☐ Yes ☐ No
2. Have formal disciplinary proceedings been initiated against this applicant's license by a disciplinary authority in your state? If yes, please explain on a separate sheet of paper and attach it to this form. ☐ Yes ☐ No
☐ Cannot answer under state law
3. Has the applicant ever been warned, censured, placed on probation, formal consent, reprimand, or in any other manner disciplined, or has the applicant's license ever been revoked, suspended, or, in any other manner, limited by a licensing or disciplinary authority in your state? If yes, please explain on a separate sheet of paper and attach it to this form. ☐ Yes ☐ No
☐ Cannot answer under state law

I CERTIFY THAT to the best of my knowledge and belief, the foregoing is a true, accurate and complete statement of the record of the individual named on this form.

AFFIX INSTITUTIONAL SEAL HERE

(If no seal is available, this form must be notarized.)

Signature _____
Print name _____
Title _____ Date _____
Phone number _____ Fax number _____
Email _____

Please mail this completed form and any other items to the board at the address listed in Section 1. Thank you.

OFFICE OF PROFESSIONAL LICENSURE AND CERTIFICATION
STATE OF NEW HAMPSHIRE
7 Eagle Square - Concord, N.H. 03301-4980
Telephone 603-271-2152

UNIVERSAL APPLICATION FOR INITIAL LICENSE

Profession for which application is being filed: _____

APPLICANT INFORMATION BASED ON TYPE OF PERSON

Applicant is (check one): ☐ An Individual ☐ An entity

For individuals:

Full Legal Name: _____
Suffix, such as "Jr." or "III", if any

Other name(s) the applicant has ever used to obtain education, profession-related training, or government services including licensure of any kind: _____

Date of birth (MM/DD/YYYY): _____

Social Security Number*: _____

*The OPLC is required by 42 U.S.C. 666(a)(13) and RSA 161-B:11, VI-a to ask for your social security number. The number will be held confidential by the OPLC and used only for enforcement of the laws governing child support.

Home Physical Address: _____
Street name & number, Apt. # if any Municipality County State Zip Code Country if not US

Home Mailing Address: ☐ Check if same as physical address

IF DIFFERENT: _____
Street name & number or PO Box number Town/City State Zip Code Country if not US

Home/Personal Telephone Number: () - _____

Designated email address*: _____

* Email address to which notices, license will be sent

If known, anticipated place of business name: _____

Address: _____
Street name & number Municipality State Zip Code Country if not US

Telephone number: () - _____

Applicant's primary language: ☐ English ☐ Other (specify): _____ Other Languages: _____

Applicant is (check if applicable): ☐ Applying for facilitated licensure

☐ Currently on active military duty*

☐ Legally married to an individual who is currently on active military duty*

* "On active military duty" means on active duty in the U.S. armed forces.

Information needed for workforce analysis, all individuals (ref. Plc 304.03(a)(10)):

☐ **PREFER NOT TO ANSWER ANY QUESTIONS**

a. Applicant's sex: [drop-down list; select one: ☐ Female ☐ Male ☐ Prefer not to answer]

b. 1. Applicant's race or ethnicity: [drop-down list; select all that apply: ☐ American Indian or Alaska Native; ☐ Asian; ☐ Black or African American; ☐ Native Hawaiian or Pacific Islander; ☐ White; ☐ Some other race; ☐ Prefer not to answer]

2. Applicant is of Hispanic, Latino/a, or Spanish origin? [drop-down list; select one: ☐ Yes ☐ No ☐ Prefer not to answer]

c. Highest level of education, whether or not related to the profession in which licensure is being sought [drop-down list, select one: ☐ High school diploma or equivalency; ☐ Some college, no degree; ☐ Technical/Vocational Certificate; ☐ Associate's Degree; ☐ Bachelor's Degree; ☐ Master's Degree; ☐ Post-graduate training; ☐ Professional/Doctorate Degree; ☐ Postdoctoral training; ☐ Prefer not to answer]

**Office of Professional Licensing and Certification
7 Eagle Square - Concord, New Hampshire 03301-4980
(603) 271-2152**

- d. Where the applicant completed the education program or degree, as applicable, that first qualified the applicant for the license being applied for, provided that if the program or degree was completed on-line, identify where the on-line program was housed [drop-down list, select one: ☐ [drop-down list of U.S. states and territories] ☐ Another Country (not U.S.): [open text field] ☐ Prefer not to answer]
- e. Relative to the applicant's employment status, whether the applicant is: [drop-down list, select one: ☐ Actively working in a position that requires this license ☐ Actively working in a position in the same profession that does not require this license ☐ Actively working in a different profession ☐ Not currently working ☐ Retired ☐ Prefer not to answer]
- f. Relative to the applicant's employment plans for the next 2 years, whether the applicant intends to: [drop-down list, select one: ☐ Increase hours in a field related to this license ☐ Decrease hours in a field related to this license ☐ Seek employment in a field unrelated to this license ☐ Retire ☐ Continue as is ☐ Not sure or plans unknown ☐ Prefer not to answer]
- g. Identification of the specialty, field, or area of practice in which the applicant spends the most professional time [drop-down list based on profession, including ☐ Other: [open text field] and ☐ Prefer not to answer]
- h. Does the applicant use or expect to use telehealth to deliver services to patients? [drop-down list, select one: ☐ Yes ☐ No ☐ Prefer not to answer]
- i. The state in which the applicant's primary practice is located, if applicable [drop-down list of U.S. states and territories plus ☐ Other: [open text field], ☐ Not applicable, and ☐ Prefer not to answer]
- j. The 5-digit zip code of the applicant's primary practice location, if applicable: ____ [open text field] ☐ Prefer not to answer
- k. Relative to the applicant's current employment arrangement at their principal practice location, whether the applicant is [drop-down list, select all that apply: ☐ Self-employed or a consultant ☐ Salaried employee ☐ Hourly employee ☐ In temporary employment or Locum Tenens ☐ Other arrangement ☐ Not employed ☐ Prefer not to answer]
- l. In the applicant's primary employment or practice, whether the applicant's primary role is that of: [drop-down list, select all that apply: ☐ Administrator ☐ Clinical practitioner ☐ Faculty or other educator ☐ Researcher ☐ Other ☐ Not applicable ☐ Prefer not to answer]

Information needed for workforce analysis, applicants in any health care field (ref. Plc 304.02(a)(11):

- a. Identification of the practice setting at the applicant's primary practice location [drop-down list based on profession plus ☐ Other: [open text field] and ☐ Prefer not to answer]
- b. What population groups does or will the applicant provide(s) services to? [drop-down list, select all that apply: ☐ Newborns to 2 years ☐ Children ages 2-10 ☐ Adolescents ages 11-19 ☐ Adults ☐ Geriatrics ages 65+ ☐ Pregnant women ☐ Veterans ☐ Incarcerated individuals ☐ Individuals with disabilities ☐ Individuals who speak a language other than English ☐ Medicaid ☐ Medicare ☐ Sliding Fee Scale ☐ None of the above ☐ Prefer not to answer]
- c. An estimate of the number of hours per week the applicant spends or expects to spend at their primary practice location [drop-down list, select one: ☐ 0 hours per week/Not applicable ☐ 1-4 hours per week ☐ 5-8 hours per week ☐ 9-12 hours per week ☐ 13-16 hours per week ☐ 17-20 hours per week ☐ 21-24 hours per week ☐ 25-28 hours per week ☐ 29-32 hours per week ☐ 33-36 hours per week ☐ 37-40 hours per week ☐ 41 or more hours per week ☐ Prefer not to answer]
- d. An estimate of the number of hours per week the applicant spends or expects to spend in direct patient care [drop-down list, select one: ☐ 0 hours per week/Not applicable ☐ 1-4 hours per week ☐ 5-8 hours per week ☐ 9-12 hours per week ☐ 13-16 hours per week ☐ 17-20 hours per week ☐ 21-24 hours per week ☐ 25-28 hours per week ☐ 29-32 hours per week ☐ 33-36 hours per week ☐ 37-40 hours per week ☐ 41 or more hours per week ☐ Prefer not to answer]

For applicants in any health care field, does applicant intend to practice in New Hampshire more than 50% of the time, whether in-person or by telehealth? ☐ Yes ☐ No

If specific training or a specific degree is required for your profession by applicable law, provide the name of the educational institution that provided the training or degree required and the date the training was completed or degree was received:

Name of educational institution: _____ Date completed/degree received: _____

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For entities:

Full Legal Name*: _____

*Name shown on document(s) that created the entity

Each other name used when doing business in New Hampshire: _____

Legal form (check one): ☐ Corporation ☐ LLC ☐ Professional Association ☐ Partnership

☐ Other: _____

Jurisdiction in which formed: _____ Date of Formation (MM/DD/YYYY): _____

Employer ID number or other federal tax ID number assigned by the IRS: _____

Primary physical address in NH: _____

Street name & number, Suite # if any

Municipality

County

Zip Code

NH mailing address: ☐ Check if same as physical address

IF DIFFERENT: _____

Street name & number or PO Box number

Town/City

Zip Code

Main telephone number: () -

Designated email address*: _____

* Email address to which notices, license will be sent

Name of Authorized Signer* (AS): _____

* Individual who is legally authorized to sign the application

AS Telephone Number: () - AS email: _____

Other contact individuals (authorized to interact with OPLC regarding the application, issued license) (if any):

Name	Telephone Number	Email Address

ALL APPLICANTS:

Information on Current or Past Licensure* in Other Jurisdictions:

Jurisdiction	License Number	Date initially licensed	Date most recently licensed	Status (in good standing, expired, suspended, revoked, denied renewal)

* Includes licenses, certificates, registrations, or other form of approval required to practice

If applying based on endorsement, identify which of the above jurisdictions you believe has requirements for licensure that are substantially similar to or greater than those in New Hampshire: _____

Background/Character Questions (“you” means the applicant); subject to “safe harbor” provisions of Plc 504.03(c):

Questions:	Yes	No
Are you now or do you have any reason to believe that you will soon be the subject of a disciplinary proceeding, settlement agreement, or consent decree undertaken or issued by a professional licensing board of any jurisdiction?		
Has any malpractice claim been made against you within the past 10 years?		
Have you, for disciplinary reasons, been put on administrative leave, been fired for cause other than staff reductions from a position at your place of employment, or had any privileges limited, suspended, or revoked in any professional setting within the past 10 years?		
Have you been denied the privilege of taking an examination required for any professional licensure within the past 10 years?		
Have you committed any act(s) within the past 10 years that would violate the laws or rules that govern the profession for which the application is being filed?		

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Have you ever been found guilty or entered a plea of no contest to any felony that is related to professional practice?		
Have you been found guilty of or entered a plea of no contest to, within the past 10 years, any felony that is not related to professional practice, or any misdemeanor?		
Have you ever been the subject of any disciplinary action by any professional licensing authority within the past 10 years?		
Have you, within the past 10 years, been denied a license or other authorization to practice in any jurisdiction?		
Have you, within the past 10 years, surrendered a license or other authorization to practice issued by any jurisdiction for any reason?		

Does applicant have a DEA number? ☐ No ☐ Yes (provide number): _____

Does applicant store, administer, or dispense controlled drugs in a setting that is not regulated under RSA 318 relative to pharmacies and pharmacists? ☐ No ☐ Yes (provide location): _____

For applicants in any health care profession (information required by RSA 125:25-c):

Do you have an ownership interest in any diagnostic or therapeutic service(s) or company(ies)? ☐ No ☐ Yes

If yes, provide the following for each service or company:

Name	Address	Specific Diagnostic/Therapeutic Services Offered

Disclosure of Contact Information*:

For individuals: Do you consent to the disclosure of any of your personal contact information? Check applicable column for each item:

Information	Yes, I consent to disclosure	No, do not disclose
Home or other personal telephone number		
Designated email address		
Home address		
Home mailing address (if different from home address)		

For entities: Do you consent to the disclosure of your designated email address? ☐ No ☐ Yes

** OPLC will not disclose this information unless authorized by you, unless ordered to do so by a court of competent jurisdiction.*

Required Documentation

Each applicant must provide the following with this application:

A clear explanation, including all relevant facts, the date(s) of the action, and the sanction(s) imposed, of the relevant circumstances of:

- (1) Any license sanctions, including fines or penalties, imposed administratively or via a court proceeding in a jurisdiction listed above; and
- (2) Any "yes" answer provided to a background and character question that is not covered by (1)

Each applicant required to provide proof of post-high school education must arrange to have the applicant's transcripts sent directly to the OPLC Licensing Bureau by the institution at which the education was obtained, as required by Plc 304.01(c).

Each applicant required to take one or more examinations (including the English proficiency score if required by applicable law) must arrange to have the applicant's examination scores sent directly to the OPLC Licensing Bureau by the third party testing organization.

**Office of Professional Licensing and Certification
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Each applicant required to be registered or certified by a regional or national credentialing organization must provide proof that the requisite credential has been obtained, or if applicable law allows an application for initial licensure to be filed prior to obtaining the credential, proof that the applicant has met the requirements for obtaining the credential.

Each applicant who obtained any required credential in a foreign jurisdiction, as defined in Plc 302.06, must provide the evaluation of foreign credentials required by Plc 303.03.

Each applicant for licensure by endorsement based on a license issued by a foreign jurisdiction, as defined in Plc 313.10(b), must provide the evaluation of foreign credentials required by Plc 313.12.

Each applicant for licensure by endorsement must provide primary source verification of licensure in the jurisdiction in which applicant is currently licensed that the applicant believes has requirements that are substantially similar to New Hampshire's requirements, that:

- (1) Identifies the applicant by name; and
- (2) Clearly shows that the applicant is authorized to practice the occupation or profession in that jurisdiction and is in good standing.

Even if not applying for licensure by endorsement, each applicant who is licensed in any other jurisdiction(s) must provide:

Either: (1) An official letter of verification sent directly to the licensing bureau at customersupport@oplc.nh.gov, or if the information cannot be sent electronically, at the mailing address for the OPLC specified in Plc 102.03, from each state that has issued the applicant a license or other authorization to practice the profession for which application is being made, that states:

- a. Whether the license or other authorization is or was, during its period of validity, in good standing; and
- b. Whether any disciplinary action is pending or was taken against the license or other authorization to practice, whether administratively or via a court proceeding;

OR: If the information required by (1), above, is available on a website and is considered by the issuing jurisdiction to be a primary source verification, the URL of each such website.

Each applicant on active military duty must provide proof of service status in the form of verification from the Defense Finance and Accounting Service at <https://www.dfas.mil/garnishment/verifyservice/>.

Each applicant for facilitated licensure as a military spouse must provide:

- (1) Proof of the spouse's service status as stated above, and
- (2) Proof of marriage in the form of either:
 - a. A copy of the front and back of the applicant's current military spouse identification card; or
 - b. A copy of the applicant's official marriage certificate, and, if the certificate is not in English, an English translation of the certificate that is certified by the translator as being an accurate translation;

Each applicant that is an entity must provide:

- (1) A copy of the legal document that confers authority on the Authorized Signer identified above to sign the application on the applicant's behalf; and
- (2) Confirmation from the New Hampshire Secretary of State's Office that the entity applying for licensure is in good standing and authorized to do business in New Hampshire.

Fee

Application-Related Fee* - as defined in Plc 302.01, except that for facilitated licensure, only the inspection fee, if any, and examination fee, if any, shall be paid

* For initial licensure, the application processing and licensing fee specified in Plc 1002, any examination fee required under Plc 303.03 or specified in Plc 1004, and any inspection fee specified in Plc 1001.18

If fee is paid by check or money order, the check or money order should be made payable to "Treasurer, State of New Hampshire." If your application is denied, the Application-Related Fee(s) will not be refunded.

Signature and Attestation

By signing below, the applicant attests that:

- The applicant is not under investigation by any professional licensing board and the applicant's credentials have not been suspended or revoked by any professional licensing board, unless a written explanation of each such occurrence is being submitted with this application;
- The information and documentation provided are true, complete, and not misleading to the best of the applicant's knowledge and belief;
- The applicant understands that providing false or misleading information constitutes grounds for denial, suspension, or revocation of a license; and
- The applicant understands that knowingly providing false material information constitutes a misdemeanor under RSA 641:3 relative to falsification in official matters.

Applicant's Signature: _____

Date Signed: _____